



# The Long Island Brain Tumor Center

at Neurological Surgery, P.C.  
J. Paul Duic, M.D. Jai Grewal, M.D.

## Neuro-Oncology Registration Form

<b>Date:</b>		<b>Referring MD:</b>				
<b>Patient Last Name:</b>		<b>First:</b>	<b>Middle:</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
<b>Is this your legal name? Yes <input type="checkbox"/> No <input type="checkbox"/> If not, what is your legal name?</b>						
<b>Marital Status:</b>		<b>Single <input type="checkbox"/></b>	<b>Married <input type="checkbox"/></b>	<b>Divorced <input type="checkbox"/></b>	<b>Separated <input type="checkbox"/></b>	<b>Widowed <input type="checkbox"/></b>
<b>Birth Date:</b>		<b>Age:</b>	<b>Sex:</b>	<b>SSN:</b>		
<b>Address:</b>		<b>City:</b>		<b>State:</b>	<b>Zip:</b>	
<b>Home#:</b>		<b>Cell#:</b>	<b>Email Address:</b>			
<b>Occupation:</b>		<b>Employer:</b>		<b>Employer Phone:</b>		
<b>Referred by:</b>			<b>Primary Care Physician:</b>			
<b>Emergency Contact:</b>		<b>Relationship to Patient:</b>		<b>Contact#:</b>		
<b>Insurance Information</b>						
<b>Person Responsible for Bill:</b>			<b>Birth Date:</b>			
<b>Address:</b>			<b>Home#:</b>			
<b>Occupation:</b>			<b>Employer:</b>			
<b>Employer Address:</b>			<b>Employer#:</b>			
<b>Is the patient covered under insurance? Yes <input type="checkbox"/> No <input type="checkbox"/></b>						
<b>Primary Insurance:</b>			<b>ID#</b>		<b>Group#</b>	
<b>Copay:</b>	<b>Policy Holder's Name:</b>			<b>Relationship:</b>		
<b>Policy Holder's SS#:</b>			<b>Policy Holder's DOB:</b>			
<b>Secondary Insurance:</b>			<b>ID#</b>		<b>Group#</b>	
<b>Copay:</b>	<b>Policy Holder's Name:</b>			<b>Relationship:</b>		
<b>Policy Holder's SS#:</b>			<b>Policy Holder's DOB:</b>			

The above information is true and to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neurological Surgery, PC or insurance company to release information required to process my claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_



# The Long Island Brain Tumor Center

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## Neuro-Oncology Clinic Patient Health History/Questionnaire

Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

What is your diagnosis? \_\_\_\_\_

When were you diagnosed? \_\_\_\_\_ Right or Left handed: \_\_\_\_\_

Recent cause of events and presenting symptoms:

\_\_\_\_\_  
\_\_\_\_\_

### Pertinent Past Medical History

Past Medical History: Please list illness and date diagnosed. Include cardiovascular disease-high blood pressure, heart attacks; diabetes, cancer and evidence of blood clots and treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you diabetic? Yes \_\_\_ No \_\_\_ Kidney problems? Yes \_\_\_ No \_\_\_ Any history of blood clots?  
Yes \_\_\_ No \_\_\_ Have you had MRI'S before? Yes \_\_\_ No \_\_\_ Are you claustrophobic?  
Yes \_\_\_ No \_\_\_

Do you have a pacemaker, defibrillator, metal implants or metal chips in brain? Yes \_\_\_ No \_\_\_

Past Surgery: Yes \_\_\_ No \_\_\_ If yes, please list here any past surgeries with approximate age at which performed:

\_\_\_\_\_  
\_\_\_\_\_

Past Radiation Therapy: Yes \_\_\_ No \_\_\_

Environmental \_\_\_\_\_

Therapy (Type) \_\_\_\_\_

Performed at: \_\_\_\_\_

Dates: \_\_\_\_\_

Total Dose: \_\_\_\_\_

Childhood Illnesses: List illness and age:

\_\_\_\_\_  
Trauma/Injuries: List type, age and consequences:

\_\_\_\_\_  
Drug Allergies: Yes \_\_\_ No \_\_\_ If yes, please list each medication separately and the side effects you experience including allergies to contrast/dye for CAT scan's and MRI's.

\_\_\_\_\_

Medications: Please list all medications, including over the counter medications, herbal and nutritional supplements, the dose you take and how often:

_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History:

Relationship	and the	Disease
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History: (Circle One) Are you currently employed, unemployed, retired, or disabled?

Occupation: (current or former) \_\_\_\_\_

Are you	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/>	Separated <input type="checkbox"/>	Widowed <input type="checkbox"/>
Live with	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Children <input type="checkbox"/>	Significant Other <input type="checkbox"/>	Other <input type="checkbox"/>

Habits:

Do you now or have you ever smoked tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how long have/did you smoke? # of years \_\_\_\_\_. If you quit, when? \_\_\_\_\_ # of years ago.

What do/did you smoke and how much per day?

Cigarettes: yes \_\_\_\_\_ no \_\_\_\_\_ # per day \_\_\_\_\_ Cigars: yes \_\_\_\_\_ no \_\_\_\_\_ # per day \_\_\_\_\_

Pipe: yes \_\_\_\_\_ no \_\_\_\_\_ # per day \_\_\_\_\_ Chew: yes \_\_\_\_\_ no \_\_\_\_\_ # per day \_\_\_\_\_

Do you drink alcohol (wine, beer, or liquor)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much per week? \_\_\_\_\_

Do you have a history of drug or alcohol abuse? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been exposed to hazardous materials? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type? \_\_\_\_\_ For how long? \_\_\_\_\_

Nutritional Status

Have you had a weight change in the last 3 months? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, number of pounds lost \_\_\_\_\_, gained \_\_\_\_\_.

Check the word(s) that describe your diet: regular \_\_\_\_\_ diabetic \_\_\_\_\_  
 soft \_\_\_\_\_ supplements \_\_\_\_\_  
 liquid \_\_\_\_\_ low salt \_\_\_\_\_

Describe your appetite: good \_\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_

Activity level-check one which applies

- \_\_\_\_\_ Fully active
- \_\_\_\_\_ Restricted in physically strenuous activity, but able to walk and do light work.
- \_\_\_\_\_ Walk without aid, capable of self-care, but unable to carry out any work activities.
- \_\_\_\_\_ Up and about more than 50% of waking hours.
- \_\_\_\_\_ Capable of limited self-care, confined to bed or chair more than 50% of waking hours.
- \_\_\_\_\_ Completely disabled; cannot do any self-care; totally confined to bed or chair.

A review of Systems Checklist follows. Please check those sections that apply to you.

<b>GENERAL</b>	<b>Y</b>	<b>N</b>	<b>GASTROINTESTINAL</b>	<b>Y</b>	<b>N</b>	<b>NEUROLOGIC</b>	<b>Y</b>	<b>N</b>
fever			trouble swallowing			seizures		
chills			nausea			spells/passing out		
night sweats			vomiting (with blood?)			headache		
weight changes (specify)			heartburn			neck stiffness/rigidity		
poor sleep			abdominal pain			personality changes		
poor appetite			diarrhea/constipation			poor memory		
fatigue			bloody or black stools			slowness of thinking		
<b>EYE</b>			hemorrhoids			trouble speaking		
blurry vision			incontinence of stool			trouble seeing on one side		
eye pain			<b>GENITOURINARY</b>			double vision		
eye discharge			painful urination			dizziness		
dry eyes			frequent urination			ringing in the ears		
<b>EAR, NOSE, THROAT</b>			excessive urination at night			weakness/paralysis (where?)		
hearing loss			blood in urine			loss of sensation (where?)		
ear pain			incontinence of urine			tingling/shooting pain		
ear discharge			kidney stones			poor coordination		
nose bleeds			sexual problems			poor balance		
nose obstruction			<b>MEN ONLY</b>			tremor (where?)		
sinus congestion			trouble starting a stream			trouble walking		
dry mouth			prostate problems			have you fallen?		
toothache			erectile dysfunction			<b>PSYCHOLOGICAL</b>		
hoarse voice			<b>WOMEN ONLY</b>			depressed mood		
swelling/lump in neck			last menstrual period:			anxiety		
<b>RESPIRATORY</b>			Could you be pregnant?			suicidal thoughts		
shortness of breath			<b>HEMATOLOGIC</b>			agitation/behavioral issues		
cough (sputum/blood?)			bruise easily			<b>DAILY LIVING</b>		
wheezing			mouth sores			Do you need help with:		
frequent colds/flu			<b>SKIN AND BREAST</b>			dressing		
<b>CARDIOVASCULAR</b>			rash			personal hygiene		
chest pain			nipple discharge			preparing meals		
palpitations			lump in breast or armpits			grocery shopping		
breathless with exertion			<b>IMMUNOLOGIC</b>			managing your finances		
known heart murmur			seasonal allergies			transportation		
skipped beats			lupus/rheumatoid arthritis			Are you currently driving?		
leg/ankle swelling			<b>MUSCULOSKELETAL</b>			Circle if use of:		
<b>ENDOCRINE (circle)</b>			joint pain (which joints?)			wheelchair		
always too cold or hot			joint stiffness			walker		
changes in skin/hair			muscle pain			cane		
			sports/traumatic injuries					

Thank you completing this questionnaire/history. The physician will review the information with you.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*The Long Island Brain Tumor Center at Neurological Surgery, P.C. Physician Information Sheet*

Referring Physician:

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Primary Care Physician:

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

*Please list any other physicians that we should send reports to regarding your care:*

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_



# The Long Island Brain Tumor Center

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J. Paul Duic, M.D. Jai Grewal, M.D.

## **HIPAA SIGNATURE PAGE**

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how medical information about me may be used and disclosed by NEUROLOGICAL SURGERY, P.C. and how I may obtain access to this information.

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Signature of Patient/Personal Representative

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Print Name of Patient or Personal Representative

Date \_\_\_\_\_



# The Long Island Brain Tumor Center

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J. Paul Duic, M.D. Jai Grewal, M.D.

## Medical Records Release Authorization

**To:**

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I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO/FROM:

**Jai Grewal, M.D. – J. Paul Duic, M.D.**

**The Long Island Brain Tumor Center**

**600 Northern Blvd, Suite 113**

**Great Neck, NY 11021**

**Tel (516)478-0010 Fax (516)482-0143**

**353 Veterans Memorial Hwy, Ste 303**

**Commack, NY 11725**

**Tel (631)864-3900 Fax (631)864-2954**

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM MY INITIAL EVALUATION TO THE PRESENT.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ENTITY IN POSSESSION OF MY MEDICAL RECORDS.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature (or authorized representatives' signature)

\_\_\_\_\_  
Name of authorized representative (if signed above)



Advance Directive for Health Care

I, \_\_\_\_\_ authorize the person(s) named below to act as my health care agent(s) and to make any and all health care decisions for me in the event that I become unable to make these decisions for myself except to the extent that I state otherwise. These health care decisions may include decisions about standard treatments, experimental treatments or clinical trials and even no further treatment. This healthcare proxy shall take effect in the event that I become unable to make my own healthcare decisions. In the event that my Primary Decision maker is unable, unwilling or unavailable to act as my healthcare agent, I also hereby appoint an Alternate Decision Maker who will then act as my healthcare agent. This Directive will remain in effect indefinitely unless I revoke it in writing.

HIPAA Release Authority: I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA) as amended from time to time.

Primary Decision Maker

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

Alternate Decision Maker

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

Telephone Numbers:

Home: \_\_\_\_\_  
 Cell: \_\_\_\_\_  
 Work: \_\_\_\_\_

Telephone Numbers:

Home: \_\_\_\_\_  
 Cell: \_\_\_\_\_  
 Work: \_\_\_\_\_

Patient Signature: \_\_\_\_\_  
 Primary Decision Maker: \_\_\_\_\_  
 Alternate Decision Maker: \_\_\_\_\_

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_

I declare that the person who signed or asked another to sign this document on his/her behalf is personally known to me and appears to be of sound mind and acting willingly and free from duress. He/she signed (or asked another to sign) this document in my presence and that person did sign in my presence. I am not the person appointed as agent in this document.

Witness: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Witness: \_\_\_\_\_

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_



## The Long Island Brain Tumor Center

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### RE: Research Advanced Directives

If you should become unable to make your own medical decisions, your designated health care proxy can make them on your behalf.

However, if you become unable to make your own medical decisions, you would be ineligible for enrollment onto a clinical trial (protocol, study), unless you specifically give a health care proxy permission to give consent for a clinical trial on your behalf. This can be established by using the attached **Research Advanced Directive** form.

You do NOT have to provide research advanced directives if you do not wish to. But so that we understand your wishes, please write “not interested” on the form so we know that you had an opportunity to think about, and discuss this issue.

Please feel free to ask us any questions you may have regarding Research Advanced Directives.



## Research Advance Directive

- 1) I, \_\_\_\_\_  
hereby appoint \_\_\_\_\_  
(name, home address and telephone number)

\_\_\_\_\_

As my research agent to make decisions for me regarding participation in research, unless I state otherwise and subject to the limitations set forth in this research advance directive. This research advance directive shall take effect only when and if I become unable to make my own research decisions.

- 2) I understand that I can revoke this research advance directive at any time. Unless I revoke it or state an expiration date or circumstances under which it will expire, this advance directive shall remain in effect indefinitely. (If you want this advance directive to expire, state the date or conditions here).

- 3) I direct my research agent to make research decisions according to my wishes and limitations, as he or she knows or as stated below. I direct my research agent to make research decisions in accordance with the following limitations and/or instructions (You may indicate the specific risk-benefit categories in which you desire to participate. Attach additional pages if necessary. Note that your research agent can only authorize your participation in research that either (i) offers a prospect of direct benefit to you, or (ii) offers no prospect of direct benefit to you, but which does not pose more than a minor increase over minimal risk.):

- Research *not involving* greater than minimum risk and presenting the prospect of direct benefit to me.
- Research *not involving* greater than minimum risk.
- Research *involving* greater than minimum risk and presenting the prospect of direct benefit to me.
- Research *involving* greater than minimum risk and no prospect of direct benefit to me, but is likely to yield information about my disorder or condition.

- Research *involving* greater than minimal risk and no prospect of direct benefit to me.

*(Indicate any additional research limitations you wish to put on your research agent's authority)*

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- 4) By signing below, I acknowledge that I understand that research is different from clinical care in that research is designed to gain new information that will help other persons in the future and not necessarily the participant in the research, i.e., me. I also understand that I may ask a court to designate a guardian to make a determination as to my participation in a particular research study.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Primary Decision Maker: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



## The Long Island Brain Tumor Center at Neurological Surgery, P.C. J. Paul Duic, M.D. Jai Grewal, M.D.

### PAYMENT POLICY

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We accept most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Copayment and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

4. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

6. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatments to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I authorize payment of medical benefits to Neurological Surgery, PC for professional services. I have read and understand the payment policy and agree to abide by its guidelines.**

**Date**

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*Signature of patient or responsible party*